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ABSTRACT

This paper describes a systematic research program examining the remedial and preventive effects of coping skills training for the management of anxiety. The general conceptual/methodological frameworks guiding the project, the rationale behind selection of fears as the target problem, and the coping skills training as the preventive intervention are presented. Five methodological steps in the development, implementation, and evaluation of prevention programs are discussed: (1) identification of the target problem; (2) selection of the target population; (3) adoption of intervention strategies; (4) selection of delivery systems; and (5) evaluation of prevention effectiveness. An examination of the primary preventive effects of the anxiety coping procedure is described; empirical support for the effectiveness of coping skills training in reducing targeted and nontargeted anxieties is also cited with evidence for the preventive capabilities of the interventions. Recommendations for future research on coping skills training and the prevention of maladaptive fears are offered. (Author/NRB)

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Coping Skills Training and the Prevention of Fears

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Running head: Coping Skills

Current behavioral research on the modification of maladaptive responses is characterized by two salient trends. First, among behavior therapists there is heightened interest in the development and identification of procedures which achieve maintenance of positive outcomes (Goldstein & Kanfer, 1979; Mash & Terdal, 1977), generalization of therapeutic effects to nontargeted maladaptive behaviors (Barrios & Shigetomi, 1979; Stokes & Baer, 1977), and prevention of debilitating response patterns (Barrios & Peterson, 1980; Barrios & Shigetomi, 1980; Gelfand & Hartmann, 1977; Peterson, Hartmann, & Gelfand, 1980; Marlatt & Gordon, 1980). Closely related, is a shift from the application of primarily externally- or therapist-controlled interventions to an active generation and wide-scale employment of treatments which emphasize client control and self-regulatory processes (Karoly, 1977; Kendall & Hollon, 1979; Mahoney & Thoreson, 1974; Stuart, 1977; Thoresen & Coates, 1976). The purpose of the present paper is to describe a systematic research program focusing on fears and anxieties which attempts to integrate these two major movements in clinical behavior therapy.

In our work, issues pertaining to maintenance and generalization of therapeutic effects are viewed within the conceptual framework of prevention proposed by Caplan (1964). According to Caplan (1964), preventive strategies can be classified in terms of three general categories. Primary prevention attempts to preclude a disorder from occurring. Secondary prevention identifies and treats a maladaptive behavior at the earliest possible moment in order to minimize the duration and severity of the psychopathology. Tertiary prevention is aimed at reducing to an acceptable level the degree of impairment associated with a disorder which has already manifested itself. Most therapeutic activities fall into the grouping of tertiary prevention (Wagenfeld, 1972), in that they are introduced after the behavioral problem has achieved sufficient intensity to warrant self-referral and/or requests by others for the individual to seek

professional assistance. Efforts to sustain and expand treatment effects are considered instances of secondary prevention, because they are directed towards preserving low levels of maladaptive responding and extending therapeutic benefits to those existing problem areas not directly addressed during the course of treatment.

Concern with preventing fears and anxieties, as well as other behavior disorders, is a relatively recent development (Cowen, 1980; Gelfand & Hartmann, 1977; Kessler & Albee, 1975). Prevention of behavior problems represents a pragmatic and cost-efficient approach to clinical practice; one which would spare individuals from unnecessary suffering and ease the shortage of treatment services. While these goals are certainly admirable, relatively few efforts have been made to design and implement programs to achieve them. A major reason for the difficulties and failures encountered by the few previous prevention programs is an insufficient adherence to the tenets of prevention methodology and the absence of a laboratory paradigm which complements, guides, and facilitates applied activities.

The development, implementation, and evaluation of prevention programs should generally conform to the following methodology (Barrios & Peterson, 1980). The first step is the identification of a target behavior or problem area whose occurrence is to be prevented. In order to be successful, a prevention program must deal with a target behavior which is prevalent and serious enough to warrant intervention. The epidemiological data on anxiety reactions and phobic disorders reveal that a large segment of the population suffers from debilitating fears (Barrios, Hartmann, & Shigetomi, 1981; Marks, 1969), and that individuals rarely exhibit discrete or monosymptomatic fears (Marks, 1969). Since fears and anxieties are experienced by such large numbers of persons, often in response to numerous and varied stimuli, preventive interventions for each separate target would be inefficient and unfeasible. A single intervention which could be

disseminated to large numbers of individuals and effectively prevent a wide range of fears over an extended period of time constitutes the ideal approach.

The second major task is to select a target population. Preventive efforts may be directed to community-wide, milestone, or high-risk populations (Bloom, 1968). In the community-wide approach, all residents receive the intervention. Milestone prevention refers to administration of intervention to individuals at specific points in their development. The high-risk strategy reaches only those individuals identified according to risk factors as likely to develop the problem behavior without treatment. Although the high-risk approach may be preferrable to the other two in terms of cost efficiency, the absence of a sensitive and economical method of identification precludes its adoption. At the present time, the milestone and community-wide, on a miniscule scale, strategies appear to be the most reasonable. Our research program currently used a randomly selected segment of the community. The goal is to move towards a milestone and eventually a high-risk approach.

The key to a successful prevention program is the adoption of cost-effective and socio-politically and ethically acceptable intervention strategies. Several previous prevention programs were based on methods lacking demonstrated efficacy as treatment interventions, thus, employing them in prevention was probably futile (Peterson et al., 1980). While treatment effectiveness is no guarantee of success as a preventive intervention, one would expect programs with a proven track record to be more efficacious in prevention than those of questionable potency. As mentioned earlier, behavior therapists are devoting increasingly more attention to the development and empirical examination of self-regulatory procedures. A resultant of this movement has been the appearance of coping skills training approaches to the management of anxiety, i.e., techniques which teach the individual an active skill such as relaxation that can be used in coping with a variety of anxiety eliciting life situations. (cf. Barrios &

Shigetomi, 1979). A review of over 60 studies on five coping skills training programs revealed the interventions to be consistently superior to no-treatment conditions, and to demonstrate some generalization of treatment effects to fears not targeted during training (Deffenbacher, Mathis, & Michaels, 1979; Deffenbacher & Parks, 1979).

Once an intervention has been selected, implementation of the program becomes the next area of concern. Preventive programs require an efficient, inexpensive method of delivery which is appropriate for both limited and wide-scale employment. In addition to its therapeutic potency, our attraction to the coping skills training approach is due to its procedural simplicity, brevity, unobtrusiveness, and demonstrated effectiveness when group administered. The techniques have also been found to be appropriate for use with both children and adults. Most importantly, coping skills training appears to circumvent the social resistance and objections evoked by most prevention efforts. Prevention programs tend to be viewed by recipients as an invasion of privacy, denial of personal freedom, and increased social control. Because of its individual-centered approach and requirement of active participation on the part of the individual, coping skills training is less likely to be perceived as disruptive or threatening to existing social structures.

The final task is the examination of prevention effectiveness. The expected preventive effects and also unexpected consequences, both desirable and undesirable, should be evaluated. Such evaluations require definable target behaviors, and intervention procedure, reliable and valid assessment techniques, and adequate research designs. Our selection of fear as the problem behavior to be prevented and coping skills training as the intervention was to a great extent determined by the fact that they lend themselves well to measurement. Although anxiety is a complex concept, numerous reliable techniques exist for assessing fears (Barrios et al., 1981; Borkovec, Weerts, & Bernstein, 1977). As a target

behavior, it is certainly more clearly defined than "mental health" or "competence", the goal of many prevention programs. The procedural simplicity of coping skills training should facilitate outcome evaluations, component analyses, and replications.

To this point, we have presented the general conceptual and methodological frameworks which are guiding our research program; and the rationale underlying our selection of fears as the target problem to be prevented and coping skills training as the preventive intervention. A number of techniques are subsumed under the heading of coping skills training. As a group, the techniques have not reliably achieved generalized effects. This inconsistency may be due to the failure on the part of the procedures to address all three response dimensions (i.e., cognitive, motoric, physiological) which comprise the anxiety construct. Inspection of current coping skills training programs indicates that the treatment packages vary dramatically with respect to the number of response channels attended to and the intensity (e.g., treatment duration, proportion of therapeutic regimen) with which each is focused upon. Thus, it is hypothesized that a coping skills training program which is comprehensive in nature (i.e., attends to all three response domains) would produce consistent generalization of therapeutic effects.

The initial investigative efforts of our research program have been devoted to developing and evaluating a coping skills training program referred to as the anxiety coping procedure. Working under the assumption that the failure on the part of coping skills training to generate reductions in nontreated anxieties is due to the incomprehensive nature of the interventions, a primary goal was to develop a treatment package which adequately dealt with the multiple, loosely related components of anxiety. Another aim was to arrive at a program which provided individuals with an integrated, manageable sequence of behaviors for coping with anxiety-eliciting stimuli. Selection and arrangement of the procedure's

components were guided by available empirical evidence and recently proposed models of behavior change (Bandura, 1977; Lang, 1977; Miller, 1979). The anxiety coping procedure consists of five major components: cue-controlled relaxation, hierarchy construction, imaginal presentation with anxiety induction, active coping, and in vivo application. We have conducted a series of investigations, employing both single-subject and group designs, which have provided initial support for the effectiveness of the procedure in reducing targeted and non-targeted anxieties; and thus the secondary and teritary preventive capabilities of the treatment.

Recently we have embarked on an examination of the primary preventive effects of the anxiety coping procedure. Conducting methodologically sound investigations on primary prevention represents an enormous challenge to clinical researchers. Essentially, investigators are focusing on a nonproblem population and monitoring their behavior for the occurrence of specific disorders. Measurement periods may be separated by considerable periods of time. As a result, a sizable proportion of one's original sample may be unavailable and one may have to rely upon crude methods of gathering data. This is particularly the case with fears, in that anxiety may appear/originate across the life span and in various contexts. A major implication of these points is that primary prevention research will be longitudinal in nature. Thus the progression and refinement of preventive strategies may be extremely slow due to the lengthy time period required to conduct outcome and component analyses. The area of prevention certainly could benefit from a laboratory model which provided relatively immediate and clinically useful information. To facilitate our examination of the preventive effects of coping skills training we have begun to utilize the laboratory model of phobias developed by Öhman and his colleagues (Öhman, 1979; Öhman, Fredrikson, & Hugdahl, 1978). Inspired by the preparedness theory of Seligman (1971), Öhman and his students have demonstrated differences among

nonfearful individuals in orienting reactions to conditionally, resistance to extinction, and habituation between potentially phobic and unprepared stimuli. The reliability of these differences between the two groups of stimuli provides us with a set of objects and laboratory procedures to investigate various preventive interventions.

In an investigation conducted this semester, 30 male and female undergraduates served as subjects. The experimental procedure consisted of five phases. First, subjects were exposed to one of three conditions: (1) taped instructions in the use of coping skills training plus accelerated practice of the technique; (2) written instructions in the use of coping skills training plus accelerated practice of the technique; or (3) no-training. Next subjects completed a packet of questionnaires dealing with reactions to test-taking situations, then shown 10 anagrams each for 5 seconds. After each anagram was presented, subjects rated their expectancy to solve that problem in the 1 minute time period which would be alloted for working on the task. Once all ratings were completed, each anagram was displayed and subjects were allowed 1 minute to rearrange the letters into a correct sequence. Subjects then were instructed to imagine various scenes depicting potentially fear eliciting stimuli (e.g., snakes, spiders, heights, darkness, sharp objects, loud noises). Duration of exposure to each imaginal representation was 1 minute. At the end of each scene, subjects provided ratings on various affective, physiological, and motoric dimensions. Throughout the entire experiment, heart and skin conductance were monitored.

Of central interest is the subjective and physiological responsivity displayed by subjects during exposure to imaginal representation of potentially phobic stimuli. On the basis of ratings of critical items on the Fear Survey Schedule II obtained prior to initiation of the experiment, fearful subjects were eliminated from the analyses. Preliminary examination of the data reveals that subjects receiving coping skills training, taped or written, reported less

subjective discomfort during imaginal exposure than control subjects. Coping skills training subjects also exhibited electrodermal and heart rate orienting responses which were of less magnitude and recovery time than control subjects. It should be emphasized that these are tentative conclusions based upon visual inspection of the data. More precised statistical analyses may suggest modifying our conclusions.

The results of our investigations provide some empiral support for the remedial and preventive effects of coping skills training. They also point out several lines for fruitful future investigative work. Among these are: (1) the identification of parameters for effective intervention; (2) delineating factors for maintenance of self-regulatory behavior; (3) examination of a milestone approach to prevention; (4) assessment of generalized effects; (5) identification of high-risk individuals; and (6) broader application and evaluation of coping skills training. We have presented a brief description of our attempt to integrate laboratory and applied research; to establish an active interplay between the two domains which will permit us to address the salient questions confronting prevention researchers. It is hoped that the merits of this approach are seriously considered by our fellow investigators, and eventually foster a more systematic, theoretically rich, and methodologically sound approach to the examination of preventive interventions,

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